

FILED FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4087

Registration District No. 160 B

Primary Registration District No. 6001

Registrar's No. 132

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town Ofallon
(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
(Specify whether
In this community SI
years, months or days)

3. (a) PRINT
FULL NAME

EMILY H. WATSON

3. (b) If veteran,
name war —

3. (c) Social Security
No. —

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased NOVEMBER 18 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 29 If less than one day hr. min.

9. Birthplace St Charles Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired teacher

11. Industry or business

MOTHER FATHER { 12. Name Watson
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Mrs. Elmer
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Madge Muschans
(b) Address Ofallon Mo

17. (a) Burial (b) Date thereof Jan 9-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ofallon

18. (a) Signature of funeral director E. A. Keith

(b) Address Ofallon Mo

19. (a) 1-20-41 (b) E. A. Keith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles
(c) City or town Ofallon Mo 92
(If outside city or town limits, write "RURAL")
(d) Street No. — (If rural, give location)
(e) If foreign born, how long in U. S. A. ? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17
year 1941 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 1937
to Jan 17, 1941.
that I last saw her alive on Jan 15, 1941.
and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured esophageal vein Duration 1/4 hr.

Due to Arterio sclerosis general

Due to —
Other conditions —
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: —
Of operations —
Of autopsy —
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? —

(Specify type of place)
While at work? — (e) Means of injury —

23. Signature Nicholas J. Honch (M. D. or other) —
Address Ofallon, Mo Date signed 1/19/41

97

2-10-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

E. Keithly

Licensed Embalmer No. *8779*

P. O. Address *Follow M*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 4087

Registration District No. 760B

Primary Registration District No. 6001

Registrar's No.

1. PLACE OF DEATH:

- (a) County St Charles
(b) City or town St Charles T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution (Specify whether)
In this community (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Emily H. Watson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

81

1

29

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

- (b) Address

17. (a)

- (b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a)

- (b)

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State

- (b) County

- (c) City or town

(If outside city or town limits write "RURAL")

- (d) Street No.

(If rural, give location)

- (e) If foreign born, how long in U. S. A.?

years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 17

year

hour

minute

M.

21. I hereby certify that I attended the deceased from

19

to

19

that last saw him alive on

and that death occurred on the date and hour stated above.

Immediate cause of death

Respiratory
esophageal vein
Cirrhosis Liver
arterio sclerosis general

Duration

1 day

4 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)

- (b) Date of occurrence

- (c) Where did injury occur?

(City or town)

(County)

(State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Nicholas J. Houch
O'Fallon, Mo.

(M. D. or other)

Date signed 4/14/47

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

